

**DECLARATION OF  
LISA DeROCHE  
EXHIBIT D**



**REQUEST FOR FAMILY MEDICAL LEAVE, PERSONAL LEAVE OR EXTENDED LEAVE**  
This leave is designated as leave granted pursuant to the Family and Medical Leave Act (FMLA)

Name: Elizabeth Augustine Emp ID: E05107  
 Department: Customer Marketing Group  
 Manager: Cynthia Stark Telephone: 212 314-2906  
 Type of Leave (Disability, Family Medical Leave, Personal Leave of Absence): Family Leave  
 Paid Time Off (Accrued and Unused) to be used 0 Days  
 Last Day Worked: \_\_\_\_\_

**Duration of Leave of Absence**

Sick Days Start \_\_\_\_\_ End \_\_\_\_\_

Short Term Disability (STD) Start \_\_\_\_\_ End \_\_\_\_\_

Paid Time Off (PTO Days)\* Start \_\_\_\_\_ End \_\_\_\_\_  
*Must be approved by your Manager*

Unpaid Family Medical Leave of Absence \* Start \_\_\_\_\_ End \_\_\_\_\_  
*Must be approved by your Manager for Leaves greater than 12 weeks (including paid sick days, STD and PTO days)*

Intermittent Family Medical Leave Start 12/21/06 End 4/15/07  
*Pending medical certification if applicable* Weekly Schedule: 3 days in office 2 days at home

Transition-Time/Medical Reduced Schedule\* Start \_\_\_\_\_ End \_\_\_\_\_  
*Must be approved by your Manager* Weekly Schedule: \_\_\_\_\_

Personal Leave of Absence\*\* Start \_\_\_\_\_ End \_\_\_\_\_  
*Must be approved by your Manager and Sr. Vice President*

**Expected Full Time Return to Work Date** \_\_\_\_\_

\* Approved by Manager: \_\_\_\_\_ Date: \_\_\_\_\_

\*\* Approved by Sr. Vice President: \_\_\_\_\_ Date: \_\_\_\_\_

**GROUP INSURANCE BENEFIT ELECTION DURING LEAVE OF ABSENCE**

☒ I elect to continue my Group Insurance coverages in force prior to my leave of absence, with the exception of Disability Pay Plans, and I agree to pay the necessary monthly contribution required by this Election. I understand that these contributions are due and payable no later than the last day of the month in which they are due. If this amount is not paid by such date, my Group Insurance coverages will terminate.

☐ I elect NOT to continue my Group Insurance coverages during my leave of absence.

Signature: Elizabeth Augustine Date: 12/14/06  
 Home Address: 9 Painted Wagon Rd Holmdel NJ 07733  
 Number and Street Address City or Town State Zip Code

12/15/05

Return Form to: AXA Financial  
 Corporate Benefits  
 100 Madison Street, MD 33-3  
 Syracuse, NY 13202  
 FAX: 315-477-3364

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**Certification of Health Care Provider**  
(Family and Medical Leave Act of 1993)

**U.S. Department of Labor**  
Employment Standards Administration  
Wage and Hour Division



(When completed, this form goes to the employee, Not to the Department of Labor.)

OMB No.: 1215-0181  
Expires: 07/31/07

1. Employee's Name

LIZ AUGUSTINE

2. Patient's Name (If different from employee)

MEGAN McEVoy

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition<sup>1</sup> qualify under any of the categories described? If so, please check the applicable category.

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) ☒ (5) \_\_\_\_\_ (6) ☒ , or None of the above \_\_\_\_\_

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Six year old with history of juvenile recurrent laryngeal papillomatosis requiring tracheostomy, recurrent airway surgery. He no longer has tracheostomy but has long term airway and lung damage as a ~~result~~ result of condition and treatment

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity<sup>2</sup> if different):

Commenced 7/00

Duration - 5 years

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 6 below)?

yes

If yes, give the probable duration:

5 years

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated<sup>2</sup> and the likely duration and frequency of episodes of incapacity<sup>2</sup>:

Chronic condition

<sup>1</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

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6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

*Cannot be predicted*

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

- b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

*Patient sees a specialist in pulmonary medicine and a pediatric ENT specialist*

- c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

*Intermittent inhalation, oxygen as needed  
steroids as needed*

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

- b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

- c. If neither a, nor b, applies, is it necessary for the employee to be absent from work for treatment?

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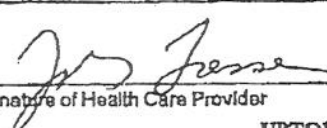
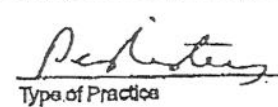
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8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

		
Signature of Health Care Provider		Type of Practice
<p>UPTOWN PEDIATRICS          Ramon J.C. Murphy, MD          John G. Larsen, MD - Signa Larsen, MD          Beth Cohen, MD - Daniel Cammerman, MD          Ivanya L. Alpert, MD          1245 Park Avenue          New York, NY 10128          Tel: 212-427-0540 Fax: 212-534-1086</p>		Telephone Number
Address		Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Preventative Care - to maintain Health  
 Specifically during winter months  
 due to cold virus's etc.

	
Employee Signature	Date

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A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition), that also involves:

- (1) Treatment<sup>3</sup> two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
- (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatment

A chronic condition which:

- (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
- (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (3) May cause episodic rather than a continuing period of incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity<sup>2</sup> which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity<sup>2</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 826.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

<sup>3</sup> Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup> A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

**Public Burden Statement**

We estimate that it will take an average of 20 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.**